DIVISION OF WORKERS' COMPENSATION

MISSOURI DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS

ENTRY OF APPEARANCE

3315 West Truman Blvd.
P.O. Box 58
Jefferson City, MO 65102-0058

_____, Health Care Provider,	)	Medical Fee Dispute No: ____ - _____
vs.	)	Injury No.: ____ - _____
_____, Employer,	)	Employee (Patient): _____
and	)	Date of Accident/ Occupational Disease: _____
_____, Insurer	)	

ENTRY OF APPEARANCE

COMES NOW, _____ attorney at law & hereby enters his/her appearance on behalf of:

- ☐ Health Care Provider
  Name _____
- ☐ Employer
  Name _____
- ☐ Insurer/Third Party Administrator
  Name _____

Respectfully submitted, _____

Name of Attorney _____

Law Firm _____

Address _____

Bar No. _____

Phone No. _____

Fax No. _____

E-mail Address _____

CERTIFICATE OF SERVICE

I, the undersigned, certify that, a copy of this Entry of Appearance has been mailed or hand delivered to all attorneys and/or all parties of record this _____ day of _____, 20____.

Attorney's Signature _____ Date _____

Attorney's Name *(Printed)* _____ Bar No. _____

Address *(if different than above)* _____

DIVISION USE ONLY

DATE STAMP